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DATE NOTICE SENT TO ALL PARTIES: Jul/08/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: PT RT shoulder 3 x 2

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: D.O., Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for PT RT shoulder 3 x 2 is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a male who reported an injury to his right shoulder as a result of lifting a gate to a pickup truck. The therapy note dated 02/23/15 indicates the patient having been recommended for physical therapy 2 x a week x 6 weeks at that time. The patient was demonstrating findings consistent with adhesive capsulitis. The therapy note dated 02/25/15 indicates the patient having initiated physical therapy. The note indicates the patient able to demonstrate 121 degrees of right shoulder flexion and 100 degrees of abduction. 4/5 strength was identified with abduction and flexion at that time. The clinical note dated 04/29/15 indicates the patient continuing with right shoulder pain. The patient rated the pain as 4-5/10 at that time. The clinical note dated 05/15/15 indicates the patient rating the right shoulder pain as 4-8/10. Numbness and tingling were identified throughout the right upper extremity. The patient was able to demonstrate an increase in range of motion at that time. The clinical note dated 05/19/15 indicates the patient having been diagnosed with a right sided AC joint sprain as well as traumatic arthropathy. The patient subsequently developed adhesive capsulitis as a result of the injury. There is an indication the patient is showing improvements with the previous therapy. The therapy note dated 06/13/15 indicates the patient having completed a full course of conservative therapy addressing the right shoulder complaints. The patient was able to demonstrate 150 degrees of right shoulder flexion, 140 degrees of abduction, and 20 degrees of adduction.

The utilization review dated 05/07/15 indicates a non-certification for a request for additional physical therapy.

The utilization review dated 06/08/15 indicates the patient having previously been certified for 12 physical therapy sessions on 09/26/14, an additional 8 sessions on 11/18/14 and a work hardening program which was prematurely discontinued.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient complaining of ongoing right shoulder pain. There is an indication the patient had been

previously approved for a total of 20 physical therapy sessions to address the ongoing functional deficits. Additional therapy would be indicated provided the patient meets specific criteria to include a significant functional improvement through the initial course of treatment as well as ongoing functional deficits. There is an indication the patient is continuing with strength and range of motion deficits in the right shoulder. However, insufficient information has been submitted confirming the patient's objective functional improvement through the previously rendered therapy. There is an indication the patient had plateaued through the course of treatment. Given the lack of significant improvements identified with the previously rendered therapy, an additional 6 physical therapy sessions are not indicated for this patient. As such, it is the opinion of this reviewer that the request for PT RT shoulder 3 x 2 is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)